County of Loudoun, VA
Request for Military Family Leave
Family and Medical Leave Act of 1993 – "FMLA"

To be completed by the employee. Copy to Benefits/Human Resources and Department Head.

Request for Family or Medical leave ***must be made at least 30 days prior to the date the requested leave is to begin.*** If the need for leave is ***unforeseeable***, the request should be submitted as soon as practical. Eligible employees must have been employed for ***12 months*** and have worked ***1,040 hours*** in the 12-month period prior to the start of the requested leave.

Employee's Name (Please print) _____ **Date of Request** _____

Address _____ **Phone Number or Extension** _____

Department Head's Name _____ **Department** _____

Reason for Request

☐ **Exigency Leave**- Eligible Employees are entitled to 12 weeks of unpaid leave during any 12-month period for "any qualifying exigency" for the spouse, child or parent of the employee who is on active duty or notified of an impending call or order to active duty in the Armed forces which includes Reserves and National Guard. "Covered military members" for the purpose of this provision include only members of the National Guard or reserves or certain retired members of the regular armed forces or reserves. Leave due to a qualifying exigency does not extend to family members of the regular armed forces on active duty status. For purposes of leave due to a qualifying exigency "son or daughter on active duty or call to active duty status" can be of any age, even though a "son or daughter' is defined for most other FMLA purposes to be under the age of 18. Completion and submission of the ***Certification of Qualifying Exigency for Military Family Leave*** (Form FLMA-201) is required.

☐ **Caregiver Leave** - An eligible employee who is the spouse, son / daughter, parent or next of kin of a covered servicemember, who is undergoing medical treatment, recuperation or therapy, and is on out-patient status or is on the temporary disabled retired list for a serious injury or illness, is entitled to 26 weeks of unpaid leave during any 12-month period. A "serious injury or illness" means an injury or illness incurred by a covered service member in the line of duty while on active duty that may render the servicemember medically unfit to perform the duties of his / her office, grade, rank, or rating. For purposes of leave under "caregiver leave", the definition of serious injury or illness it is not the same as a "serious health condition" for other FMLA purposes. Completion and submission of the ***Certification for Serious Injury or illness of Covered Servicemember for Military Family Leave*** (Form FMLA-202) is required.

Beginning Date of Requested Leave: _____ Expected Date of Return: _____

Spouse/Family member's name and relationship: _____

Is spouse an employee of Loudoun County Government: ☐ YES ☐ NO

If "yes", spouse's department: _____

Total Number of Weeks Requested: _____

Total Number of Hours / Days ***(if intermittent only):*** _____

Please give specific details of your reason for requesting leave. If you are taking leave to care for a seriously ill family member, state the care you will provide and an estimate of the time period during which this care will be provided:

_____

_____

_____

_____

Intermittent or Reduced Schedule

If you are requesting leave on ***an intermittent or reduced schedule,*** please describe your needed leave below (i.e. attend deployment, settling legal matters, or financial matters,). Intermittent or reduced schedule leave may be taken.

_____

_____

_____

_____

This Request for Military Family Leave must be submitted to Human Resources / Benefits with a copy to the employee's Department Head. Appropriate supplemental forms and supporting documents should be submitted to Human Resources/Benefits.

If your request is for ***Caregiver Leave*** of your spouse, child or parent or next of kin, you must submit a ***Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave*** (Form FMLA-201) from the treating physician ***within 15 days of the application for leave***.

If your request is for **Exigency Leave**, you must complete and submit a ***Certification of Qualifying Exigency For Military Family Leave*** (Form FMLA-202) ***within 15 days of the application for the leave.***

Additional documentation may be required beyond the initial requested information.

I certify that the information given on this form is true. I understand that making false statements on this form is grounds for discipline up to and including termination of my employment. I further understand that a failure to return to work at the end of my approved leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by Loudoun County. I acknowledge that it is my responsibility to provide a copy of this form to my Department Head and submit the original to Human Resources / Benefits.

_____ _____

Employee's Signature **Date**

PAYROLL / FMLA

You must provide this section to your departmental payroll liaison in order to be paid according to your designation below.

You must designate the amount and types of your accrued leave to be used while on approved FMLA beginning _____.

	Hours / Day(s)	Week(s)	Pay Period(s)
Earned Sick Leave	_____	_____	_____
Earned Annual / Personal	_____	_____	_____
Leave Without Pay**	_____	_____	_____
*TOTAL	_____	_____	

*Total should equal the amount of leave requested. 1 week = 7 days (workweek is Thurs – Wed) FMLA = 12 weeks

**Refer to Notice Regarding Continued Health Insurance Coverage.

_____ _____

Employee's Signature Date